Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number:

#### Filing at a Glance

Company: American United Life Insurance Company

Product Name: Statement of Insurability SERFF Tr Num: AULD-127685909 State: Arkansas TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved State Tr Num: 49976

Sub-TOI: H11G.004 Other Co Tr Num: STATEMENT OF State Status: Approved-Closed

**INSURABILITY** 

Filing Type: Form Reviewer(s): Donna Lambert

Authors: Bridget McGill, Angie Disposition Date: 10/12/2011

Neville, Danita Ragland-Hatton

Date Submitted: 10/07/2011 Disposition Status: Approved

Implementation Date Requested: On Approval Implementation Date: 11/14/2011

State Filing Description:

#### **General Information**

Project Name: Status of Filing in Domicile: Pending

Project Number: Date Approved in Domicile:
Requested Filing Mode: Domicile Status Comments:

Explanation for Combination/Other: Market Type: Group

Submission Type: Group Market Size: Small

Group Market Type: Employer Overall Rate Impact:

Filing Status Changed: 10/12/2011
State Status Changed: 10/12/2011
Deemer Date:

Created By: Angie Neville Submitted By: Angie Neville

Corresponding Filing Tracking Number:

Filing Description:
October 7, 2011

Re: American United Life Insurance Company - NAIC #60895

Statement of Insurability, G-23223-EOI

Form to be used with Group Life and Disability Income Insurance and Individual Life Insurance forms

Dear Department of Insurance:

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number:

Attached for approval is the Statement of Insurability form. This form is new and does not replace any existing forms on file with your Department. This form may be used when applying for the following products on file with your department: (1) group term life insurance; (2) group disability insurance; and (2) individual life insurance. We are filing under life and disability separately. The Life SERFF tracking number for life is AULD-127685512. This form was filed in our domiciliary state, Indiana, on September 30, 2011, and is pending approval.

This form will be used at enrollment to medically underwrite individuals who apply for:

- An amount of group term life insurance coverage or group disability income insurance coverage above the Guaranteed Issue Amount;
- •Group term life insurance coverage or group disability income insurance coverage as a Late Enrollee;
- A change in group term life insurance coverage or group disability income insurance coverage if the policy requires the completion of evidence of insurability; or
- Individual life insurance coverage

American United Life Insurance Company (AUL) wishes to market individual whole life insurance to employees whose employers have group insurance with AUL. So the employee does not have to answer underwriting questions twice, once with the whole life insurance application and then again, where appropriate, when enrolling for group coverage, this Statement of Insurability form will be used to medically underwrite for both the whole life insurance and if applicable, for the group insurance products as listed above.

Variable language has been marked with brackets which generally indicate optional benefits or provisions. If the language is changed, it will never be less favorable than your state's laws allow.

Please acknowledge approval of this form via SERFF.

You may call me at 317-285-1809 or contact me by e-mail at productcompliance.corporatecompliance@oneamerica.com if you have any questions. Thank you for your assistance with this filing.

Sincerely,

Bridget McGill
Senior Contract Analyst
Corporate Compliance and Market Conduct

## **Company and Contact**

#### **Filing Contact Information**

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number:

Bridget McGill, Sr. Contract Analyst Bridget.McGill@oneamerica.com

One American Square 317-285-1809 [Phone]

Indianapolis, IN 46206

**Filing Company Information** 

American United Life Insurance Company CoCode: 60895 State of Domicile: Indiana

One American Square Group Code: 619 Company Type:

P.O. Box 7127 Group Name: State ID Number:

Indianapolis, IN 46206 FEIN Number: 35-0145825

(877) 285-7660 ext. [Phone]

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#### **Filing Fees**

Fee Required? Yes Fee Amount: \$50.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY AMOUNT DATE PROCESSED TRANSACTION #

American United Life Insurance Company \$50.00 10/07/2011 52582415

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number:

# **Correspondence Summary**

#### **Dispositions**

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	10/12/2011	10/12/2011

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number: /

### **Disposition**

Disposition Date: 10/12/2011 Implementation Date: 11/14/2011

Status: Approved

Comment:

Rate data does NOT apply to filing.

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number: /

**Schedule** Schedule Item **Schedule Item Status Public Access Supporting Document** Flesch Certification Approved No **Supporting Document** Application Approved No **Supporting Document** Statement of Variables Approved No **Form** Statement of Insurability Approved No

Company Tracking Number: STATEMENT OF INSURABILITY

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number: /

#### Form Schedule

Lead Form Number: G-23223-EOI

Schedule	Form	Form Type Form Name	Action	Action Specific	Readability	Attachment
Item	Number			Data		
Status						
Approved	G-23223-	Application/Statement of	Initial		50.200	G-23223-
10/12/2011	EOI	Enrollment Insurability				EOI.pdf
		Form				

### Statement of Insurability

Section A: Proposed Insured (complete Statement of Insurability)

Products and financial services provided by American United Life Insurance Company® a OneAmerica® company One American Square, P.O. Box 368 Indianapolis, IN 46206-0368 1-800-553-5318



Proposed Insured Name: _			***************************************		y 48-41-197-1	are an annual market and a second a second and a second a
D	river's License Nun	nber		State where Issu	ed	
pd =	-	in. Weight				
Spouse and/or Child(rer Whole Life Insurance Co	verage not availa	ble for Spouse/Ch	nildren.		· ·	
Spouse/Partner Name (Las	t, First, Middle)	Gender LJ M LJ F Driver's License # _	Birth Date	Bi St	rth Place ate where Issue	ed
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				Authorized	to Reside in U.	S. 🗆 Yes 🗆 No
Child Name (Last, First)	elle entre massinge - metmory entre mit departe massing in despate in reflected models	Relationship to You Gender  M  F		Fu		☐ Yes ☐ No
Billion William (Charles Control and Charles C		Height	Weight	Authorized		
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Underwriting Information				r Name in a square and general square distribution desperant and a square and a square and a square and a square		
Section B: Health Questi	ions	A CONTRACTOR	. C. 1		a Kalendaria	
1. Within the past 7 years,	has any applicant f	or insurance been d	liagnosed or tre	ated by a physicia	ın or medical pr	rofessional,
tested positive for the pr condition questions, and	esence of, or taken	prescribed medicir	ne for the follov	ving: <i>(Čircle condi</i>	tions that apply	or in multi-
condition questions, and	i provide idii detaii:	s wany yes respu	mse ni secuon	4./	(martine)	•
				Proposed	Spouse	Children
				Proposed Insured	Spouse	
a. Cancer, malignancy, o	· ·			Insured ☐ Yes ☐ No	Yes N	o  □ Yes □ No
b. Diabetes, thyroid, or o	other glandular diso	rder?		Insured ☐ Yes ☐ No	Yes N	
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2. V		s any applican	t for insurance: <i>(Circle informati</i>	on that ap	pplies in multi-	part questions,	and provide full
a	etails to any "yes" respon	ise in Section	4.)		Proposed Insured	Spouse	Children
a	. Had a checkup or consu	ıltation with a p	physician or medical practitioner:	<b>)</b>		☐ Yes ☐ No	☐ Yes ☐ No
k	. Been an inpatient or out similar entity?	patient in a ho	spital, clinic, or medical facility o	any	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	·	. "	, any prescription medicine?		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	biopsy, or any other diag	nostic testing		,	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	not been completed?		est, hospitalization, or surgery wh		□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No
,	sickness, disability, or in school, or perform the n	npaired conditi	npensation, or pension for any inj on, and/or been unable to work, a s of like age and gender or been	nttend	□ Vae □ No	☐ Yes ☐ No	Voc No
Ç	g. Received or been instructed to seek treatment for use or abuse of:						
ŀ	☐ Alcohol ☐ Drugs?  Used parcetics, cocaine	ISD heroin i	marijuana quaaludes amphetami		∟ Yes ∟ No	☐ Yes ☐ No	Yes L No
	h. Used narcotics, cocaine, LSD, heroin, marijuana, quaaludes, amphetamines, barbiturates, inhalants, or any other habit-forming drug or substance, whether prescribed or non-prescribed?				□ Yes □ No	☐ Yes ☐ No	☐ Yes ☐ No
	. Had any surgical proced surgery?		loss? If so what was date of				
	What was your pre-surg	ery weight?			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	insurance?		ned, or modified for life or disabili			☐ Yes ☐ No	1
	•		ion, or treatment other than state i <b>ls to any "yes" response in Sect</b>		L Yes L No	☐ Yes ☐ No	☐ Yes ☐ No
â	. Pregnant? Expected deli complications or high ris high blood pressure, dia . Has any applicant ever u as gum, patch, etc.) and,	very date: sk issues, inclu betes multiple used any nicoti for tobacco pro	List current or ding but not limited to pregnancy gestations, i.e., twins, etc in Sect ne (including substitutes such oducts? If Yes, provide detail belo	past related ion 4.)		☐ Yes ☐ No	
	Name 1. ☐ Present ☐ Forme						•
	2. Type of nicotine or tobacco used:						mana dagram mayarin ang mang ang ang ang ang ang ang ang ang ang
	3. When did the applicant quit using all forms of nicotine (including substitutes) or tobacco? month/ye If more than one applicant has used nicotine, provide full details in Section 4.					month/year	
4. D	• •		from Questions 1-3. If needed, us		e sheet of pap	er.	
	Name	Question No.	Details of injury, illness, or disorder	Date	Name of Phy	sician, Hospital, o	r Other Provider
	нун калиноом мундуулас-каларындуу даура эде милуууласунду түүлдөгү зайууласы зайууласы ортоучий түрсөгү	ignade neutropper y Orokonomisty procest y antigenomy na opropriosa	увен ну болош ну туро обърски мојуску и јавијуски проме на болош добо на неву на вен на променени на променени	***************************************	a diging a part of part of the side of the	egyaran menenggan kalan salah sa	<b>20 жы</b> ны <i>рага жан</i> жан мулуулуу иштануу уйда
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	HPANICATE AGAIN A PERSONAL PROPERTY FOR THE STATE OF THE			Marine Moore		escende communicación de la co	
-	وجروب ويون وينه وينه وينه وينه وينه وينه والمساحقة والمنظور وينه وينه والمنتج في ينها وينه وينه المراجع وينته		dan manaka dan menunak pemerunak dilikar selam kumbunkan dan dibiban menunak behidan dilik bilak dibibah dahid pemerunak bu		gan jigan mengan pelaksishina matekhina matekhina matekhina mengan samungan samun	general establishment of the second s	Managampalitanan jargamin na hipanyay quanar ( ajamar napya) a b
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#### **Authorization and Acknowledgement**

I/we authorize any physician, medical practitioner, hospital, medical facility, insurance company, pharmaceutical databases, DMV and the MIB to give to American United Life Insurance Company® (AUL) and its reinsurers any of the following information about mediand my spouse and/or my dependents, if they are to be insured) facts about physical and mental health; medical care, advice or treatment; prescriptions, hobbies, other insurance, flying record, and driving record (which may include but is not limited to existing address); age, occupation, income and the use of alcohol, drugs and tobacco. This authorization does not authorize the release of genetic screening or testing results. All sources except the MIB may give these facts to any insurance support organization authorized by AUL to collect and transmit them. This data will be used to determine eligibility for insurance. A photocopy of this form shall be as valid as the original. This authorization will be valid for 24 months from the date shown below. In Arizona, this authorization is limited to 180-days for disclosure of HIV-related information (I/we understand that any person requesting to be insured may be asked to take a physical exam, where tests may be made of blood and urine. These tests may include tests for the presence and/or level of blood sugar, cocaine or other drugs, cholesterol, nicotine and, where permitted by law, antibodies to the Acquired Immune Deficiency Syndrome virus. If an investigative consumer report is made I/we can choose to be interviewed and to receive a copy of the report upon request.

The undersigned: 1) represents that the statements and answers given on this form are true and complete to the best of my/our knowledge and belief; 2) understands and agrees that any insurance that shall be issued is in consideration of these statements being complete and correct and benefits under any policy will be paid only if AUL or its claims administrator decides in its discretion the applicant is entitled to them; 3) //we certify that all notices contained herein were read and understood prior to my/our) completion of this form; 4) has received and kept a full and complete copy of this Statement of Insurability, as well as any changed or updated copies involved in the underwriting of this request for insurance; and 5) has received the Notice of Insurance Practices, the Medical Information Bureau Notice, the Fair Credit Reporting Act Notice and this Authorization and Acknowledgment.

Signatures			
Signature of Proposed Insured / Employee	Mo. / Day / Year	Signature of Spouse / Partner	Mo. / Day / Year
Printed Name of Proposed Insured / Employee		Printed Name of Spouse / Partner	
		Signature of Dependent Child Age 18+	Mo. / Day / Year
		Printed Name of Dependent Child Age 18+	den disking mendeling disking disking ang mengengan pengengan pengengan dan beraman disk

STATEMENT OF INSURABILITY Company Tracking Number:

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other

Product Name: Statement of Insurability

Project Name/Number:

## **Supporting Document Schedules**

Item Status: **Status** 

Date:

Flesch Certification Approved Satisfied - Item: 10/12/2011

Comments:

Attachments:

Standard Cert of Compliance \_Blank\_.pdf

READCERT.pdf

**Item Status:** Status

Date:

Application Approved 10/12/2011 Bypassed - Item:

N/A **Bypass Reason:** 

Comments:

**Item Status:** 

**Status** 

Date:

Satisfied - Item: Statement of Variables

Comments:

Attachment:

Statement of Variables - G-23223-EOI.pdf

Approved 10/12/2011

# CERTIFICATE OF COMPLIANCE

# State of Arkansas

I, Jay B. Williams, Vice President Chief Compliance Officer, of the AMERICAN UNITED LIFE INSURANCE COMPANY®, hereby certify that the enclosed Forms comply with all Insurance Statutes, Regulations, and Departmental requirements of the State of Arkansas.

Jay B. Williams

Vice President Chief Compliance Officer

Jay B. Williams

Date: October 6, 2011

#### CERTIFICATE OF READABILITY

I, Jay B. Williams, Vice President and Director of Compliance of American United Life Insurance Company, hereby certify that the following forms have the following readability scores as calculated by the Flesch Reading Ease Test and that these forms meet the reading ease requirements.

FORMS READABILITY SCORE

G-23223-EOI 50.2

October 6, 2011 Jay B. Williams

Vice President and Director of Compliance

# STATEMENT OF VARIABLES G-23223-EOI

FORM NUMBER	SECTION TITLE	PROVISION/ DESCRIPTION	BRACKETED VARIABLES EXPLANATION
G-23223-EOI	Statement of Insurability	Company address/phone number	Bracketed for ease in updating as need arises should there be a change in the company address or phone number.
u	u .	OneAmerica (logo)	Bracketed for ease in updating the logo in case it is changed.
66	Section A	Spouse and children	Bracketed so the spouse and children questions may be deleted if evidence of insurability information for spouse and children are not applicable.  Bracketed for ease in updating as need arises whenever there is a change in product(s) offered to the spouse and children— the change could be in a product name or it could be a new product that has been filed and approved by the state
"	Section B	Spouse and Children columns	Bracketed so the spouse and children area may be deleted if evidence of insurability for spouse and children are not applicable.
"	Authorization and Acknowledgement	"I/we", "my/our" and "(and my spouse and/or my dependents, if they are to be insured)"	Bracketed so the references to spouse and children may be deleted if evidence of insurability for spouse and children are not applicable.
u	Signatures	Signatures for Spouse and children	Bracketed so the spouse and children signature items may be deleted if evidence of insurability for spouse and children are not applicable.